IN THE DISTRICT COURT
AT WELLINGTON

I TE KŌTI-Ā-ROHE
KI TE WHANGANUI-A-TARA

[2023] NZACC 34 **ACR 94/22**

UNDER	THE ACCIDENT COMPENSATION ACT 2001
IN THE MATTER OF	AN APPEAL UNDER SECTION 149 OF THE ACT
BETWEEN	DHIRENDER KUMAR Appellant
AND	ACCIDENT COMPENSATION CORPORATION Respondent

Hearing: 2 March 2023

Held at: Wellington/Te Whanganui-a-Tara by AVL

Appearances: The Appellant is self-represented
C Sinclair and S Kinsler for the Respondent

Judgment: 7 March 2022

RESERVED JUDGMENT OF JUDGE P R SPILLER
[Treatment injury - s 32, Accident Compensation Act 2001 ("the Act")]

Introduction

[1] This is an appeal from the decision of a Reviewer dated 7 June 2022. The Reviewer dismissed an application for review of the Corporation's decision dated 23 June 2016 declining Mr Kumar cover for hepatitis C as a treatment injury.

Background

[2] Mr Kumar was born in July 1993 in India.

[3] On 7 February 2012, Mr Kumar was granted a student visa to study in New Zealand, and he arrived here shortly afterwards. On 1 October 2014, he was granted a New Zealand work visa, and he worked as an assistant herd manager.

[4] On 12 January 2015, Mr Kumar suffered a sudden headache with drowsiness and vomiting. He later became unconscious and was admitted to Palmerston North Hospital. A CAT scan showed a large posterior fossa haemorrhage with an associated arterio-venous malformation (AVM).

[5] On 13 January 2015, Mr Kumar was transferred to Wellington Hospital, where an emergency posterior fossa craniotomy was performed with insertion of an extra-ventricular drain (EVD). Subsequent angiography showed a large cerebellar AVM.

[6] On 19 January 2015, Mr Kumar underwent further surgery in Wellington, involving drainage of a large posterior fossa meningocele.

[7] On 30 January 2015, Mr Kumar returned to Wellington Hospital for reinsertion of the EVD. Recovery was slow, but he was eventually transferred back to Palmerston North hospital on 3 March 2015.

[8] On 8 July 2015, Mr Kumar had surgery at Dunedin Hospital to prevent further bleeding from his abnormal blood vessels.

[9] On 21 January 2016, Mr Kumar applied for an Essential Skills work visa. On 22 February 2016, Mr Kumar underwent a medical assessment as part of his visa application, and it was discovered that Mr Kumar was positive for hepatitis C. On 22 April 2016, his visa application was declined on this basis.

[10] Mr Kumar sought cover for hepatitis C as a treatment injury. He asserted that he received a blood transfusion as part of his treatment at Wellington Hospital, and that this was how he contracted hepatitis C.

[11] On 28 April 2016, Dr Mark Lockwood, GP, noted that Mr Kumar had undergone a full batch of blood tests before coming to New Zealand and did not have hepatitis C at that time. Dr Lockwood said that Mr Kumar subsequently

underwent several procedures to treat his brain haemorrhage, including a blood transfusion. Dr Lockwood considered it "most likely" that Mr Kumar contracted hepatitis C as part of his emergency treatment in New Zealand.

[12] On 23 June 2016, the Corporation declined cover on the ground that there was no evidence that Mr Kumar received blood or blood products while he was an inpatient at Wellington Hospital. Mr Kumar applied for review of this decision.

[13] On 20 January 2022, Dr S Gibbons, the Corporation's clinical advisor and haematologist, noted that there was no evidence in the medical records that Mr Kumar underwent a blood transfusion. Dr Gibbons also noted that Mr Kumar did not undergo any blood tests for hepatitis C while he was in hospital, so it was impossible to know whether he had already contracted the condition by then. Dr Gibbons suggested that the more likely cause was exposure to hepatitis via the sharing of items such as toothbrushes or razors, or another item contaminated with a small amount of blood from a person carrying the virus. Dr Gibbons concluded that there was no evidence that Mr Kumar's hepatitis C was caused by his treatment.

[14] On 9 May 2022, Mr S K Goswami, a Senior Surgeon in India, reported, after his analysis of the medical notes from Wellington, Palmerston North and Dunedin hospitals. Mr Goswami assessed that Mr Kumar's treatment would not have been possible without transfusing blood or blood products, "which may be directly or indirectly associated with his viral hep C". Mr Goswami also noted that a physical check-up did not reveal Mr Kumar to have any tattoos, signs of religious scarification or previous drug injections on his body.

[15] On 27 April 2022, review proceedings were held, and these were concluded on 11 June 2022. Mr Kumar stated that he became anaemic during his treatment at Wellington Hospital and therefore required a blood transfusion. He recalled seeing needles inserted into his right arm and pouches of blood on a stand. Mr Kumar's brother provided a statement that he was present during Mr Kumar's treatment at Wellington Hospital and had witnessed Mr Kumar receiving a blood transfusion.

[16] On 7 June 2022, the Reviewer held that Mr Kumar had failed to show, on the balance of probabilities, that he contracted hepatitis C as the result of his hospital treatment. On 8 June 2022, a Notice of Appeal was lodged.

[17] On 6 October 2022, the New Zealand Blood Service (NZBS) confirmed that, while it performed a blood group test on Mr Kumar in its Wellington Blood Bank in 2015, it has never issued any blood to him for transfusion. NZBS therefore advised that, if Mr Kumar has had a transfusion, this is likely to have taken place either overseas or before NZBS was established in 1998.

[18] On 25 November Dr Peter Flanagan, Transfusion Medicine Specialist at NZBS, provided a medical opinion for this matter. Dr Flanagan reported:

> … there is no indication at any point in the hospital notes of a prescription, completed A109 form, or any documentation that any transfusion has taken place in the operating and anaesthetic records or in the written hospital patient record. The absence of any record of blood components being transfused in either the NZBS e-Traceline system or the patient's hospital record indicate, in my opinion, that DK did not receive a transfusion during his period of hospital admissions in 2015. Errors can occur in hospital records but in my experience, normally involve one or two parts of the documentation of the transfusion to be absent or incomplete. The likelihood of a transfusion having taken place when there is no record held by the blood bank or present in the hospital record must be extremely low indeed. …
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> … whether any transfusion given to DK would have been documented by the blood bank. There is only one scenario when this might not occur. This would be if DK had received a blood transfusion that was issued by the blood bank for another patient and inadvertently transfused to DK. This is a very rare occurrence and I am aware of only two such cases being reported since July 1998 when NZBS was established a period during which around 5 million blood components will have been transfused. However, when these cases do occur there is normally a record of the patient being transfused in the patient's hospital record and the error becomes apparent when the blood bank receives a request to issue a component to the intended patient. …
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> … The blood group testing performed on DK will likely have been requested prior to him going to theatre for his initial surgery … It is standard practice for a 'group and screen' to be performed on patients prior to surgery if there is a risk of significant blood loss. … The results of the blood group and antibody screen will determine which specific blood components are selected for any individual patient. The results of pre-transfusion testing will be entered into the patient's e-Traceline file and transferred to the hospital electronic health record. There is no possibility of a patient contracting hepatitis C as a consequence of this testing.
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> … [DK's] haemoglobin post-operatively on 13/01/2015, measured using a blood gas analyser, was recorded as 133g/L. This is a normal result for a man

of his age. The records provided include several hand written comments as to his haemoglobin level in the weeks following surgery. On all occasions the value was over 100g/L. … DK was a previously healthy young man and would likely only have been transfused if his haemoglobin had fallen below 70g/L. Based on the information provided to me, this did not occur and so I would not expect him to have been transfused. …

Hepatitis C is readily transmitted by blood transfusion. Prior to the introduction of routine testing for the virus it was acknowledged as one of the most important transfusion transmitted infections. New Zealand introduced testing of all donated blood for hepatitis C antibody in 1992. In 2000 this was reinforced with the use of direct testing for the virus itself (HCV RNA). There are no documented cases of hepatitis C transmission by transfusion in New Zealand since antibody testing was introduced in 1992. This is now 30 years ago and more than 6 million components will have been transfused since this commenced. The risk of hepatitis C transmission by tested blood in New Zealand is therefore now remote. … The pattern of virus positive results in blood donors in New Zealand has remained reasonably constant over the last several years reflecting the international situation.

Hepatitis C is a blood borne infection. Transmission from one person to another requires passage of blood parenterally i.e. surface contact alone is unlikely to lead to transmission. Hygiene standards in New Zealand hospitals are high. Medical devices and consumables are either single use or subject to effective cleaning/sterilisation between procedures. Fibre-optic endoscopes can be difficult to clean and there are reports of potential cross-infection associated with this. The risk exists only when biopsy is performed. There have been occasional incidents in New Zealand related to these instruments over the last 20 years or so but, to my knowledge, none have resulted in transmission occurring. DK did not undergo fibre-optic endoscopy during his stay in hospital. The likelihood of him acquiring hepatic C during his treatment must be seen as remote. …

… The absence of symptoms attributable to hepatitis C infection prior to his admission to Wellington hospital is not helpful in determining when he became infected with the virus. Most importantly it does not exclude him already being infected with the virus. The only way to exclude this would be for him to provide evidence of negative test results for hepatitis C performed prior to his admission. …

… the absence of any record of transfusion during his admission in 2015 and the very low residual risk of hepatitis C associated with transfusion in New Zealand indicates that he did not acquire the infection by this route.

Relevant law

[19] Section 32 of the Accident Compensation Act 2001 ("the Act') provides:

32 Treatment injury

(1) Treatment injury means personal injury that is—

(a) suffered by a person—

(i) seeking treatment from 1 or more registered health professionals; or

(ii) receiving treatment from, or at the direction of, 1 or more registered health professionals; or

(iii) referred to in subsection (7); and

(b) caused by treatment; and

(c) not a necessary part, or ordinary consequence, of the treatment, taking into account all the circumstances of treatment, including

(i) the person's underlying health condition at the time of the treatment; and

(ii) the clinical knowledge at the time of the treatment.

(2) Treatment injury does not include the following kinds of personal injury:

(a) personal injury that is wholly or substantially caused by a person's underlying health condition:

(b) personal injury that is solely attributable to a resource allocation decision:

(c) personal injury that is a result of a person unreasonably withholding or delaying their consent to undergo treatment.

(3) The fact that treatment did not achieve a desired result does not, of itself, constitute a treatment injury.

[20] In the Court of Appeal judgment in *Adlam*,[1] Cooper J stated:

> [62] Taken as a whole the provisions indicate a legislative intent to limit cover for persons who suffer injury while undergoing treatment, rather than providing cover for all those who suffer. The injury said to be a treatment injury must be the consequence of a departure from appropriate treatment choices and treatment actions. The drafting could have simply provided for cover for all injury suffered while a person undergoes treatment. But that course was not taken. Rather, boundaries were set out that have the effect of limiting the availability of cover for injury during treatment. A failure in the sense of omitting to take a step required by an objective standard is necessary. …
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> [65] As is always the case, it is necessary to focus on the words Parliament has actually used. It will be apparent from our reasoning that we have discerned a legislative policy that, while not requiring a finding of negligence, still operates on the basis that a treatment injury will only have occurred where there has been some departure from a standard and that departure has caused a personal injury.

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1 *Adlam v Accident Compensation Corporation* [2017] NZCA 457, [2018] 2 NZLR 102 at [62] and [65]; see also *McEnteer v Accident Compensation Corporation* [2010] NZCA 126, [2010] NZAR 301 at [20].

[21] In *Ambros*,[2] the Court of Appeal stated the following in relation to causation:

> [65] The requirement for a plaintiff to prove causation on the balance of probabilities means that the plaintiff must show that the probability of causation is higher than 50 per cent. However, courts do not usually undertake accurate probabilistic calculations when evaluating whether causation has been proved. They proceed on their general impression of the sufficiency of the lay and scientific evidence to meet the required standard of proof ... The legal method looks to the presumptive inference which a sequence of events inspires in a person of common sense
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> …
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> [67] The different methodology used under the legal method means that a court's assessment of causation can differ from the expert opinion and courts can infer causation in circumstances where the experts cannot. This has allowed the Court to draw robust inferences of causation in some cases of uncertainty -- see para [32] above. However, a court may only draw a valid inference based on facts supported by the evidence and not on the basis of supposition or conjecture … Judges should ground their assessment of causation on their view of what constitutes the normal course of events, which should be based on the whole of the lay, medical, and statistical evidence, and not be limited to expert witness evidence
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> …
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> [70] … The generous and unniggardly approach referred to *Harrild* may, however, support the drawing of a robust inference in individual cases. It must, however, always been borne in mind that there must be sufficient evidence pointing to proof of causation, on the balance of probabilities, for a Court to draw even a robust inference on causation. Risk of causation does not suffice.

[22] In *Sam*,[3] Mallon J stated:

> [24] Having assessed what are the range of possible causes on the evidence, I reject the submission that, if any of the possible causes would be covered, it is for ACC to disprove that cause. I agree with ACC that *Accident Compensation Corporation v Ambros* [2008] 1 NZLR 340 does not support such an approach. Rather *Ambros* upheld the position previously taken in an earlier case that the legal burden of establishing causation on the balance of probabilities remains on the claimant.

[23] In *Bloomfield*,[4] Judge Joyce stated:

> [18] In this case, and when all is rendered down, the extension of cover claims pursued on appeal by Mr Bloomfield rest mainly on the foundation of a temporal connection argument. On occasion, a temporal connection may be of

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2 *Accident Compensation Corporation v Ambros* [2007] NZCA 304, [2008] 1 NZLR 340.

3 *Sam v Accident Compensation Corporation*, CIV 2008-485-829, High Court, Wellington, 31 October 2008.

4 *Bloomfield v Accident Compensation Corporation* [2014] NZACC 1: reference to the mistaken notion that, because one happening follows another, the first has caused the second

> significance in the context of other, helpful to a claimant, evidence. But the mere presence of such a connection will usually do no more than raise the *post hoc ergo propter hoc* fallacy.

[24] In *Stewart*,[5] Judge Barber stated:

> [33] The cases consistently highlight that the question of causation cannot be determined by a matter of supposition. There must be medical evidence to assist the respondent Corporation, and now the Court, to determine that question. A temporal connection, in itself, will be insufficient. There needs to be a medical explanation as to how the ongoing condition has been caused by the originally covered injury.

Discussion

[25] The issue on appeal is whether, on the balance of probabilities, Mr Kumar's hepatitis C was caused by hospital treatment he received for a brain haemorrhage. Mr Kumar is required to show that he suffered a personal injury caused by receiving treatment from registered health professionals, and this injury was not a necessary part, or ordinary consequence, of the treatment. A treatment injury will only have occurred where there has been some departure from a standard and that departure has caused Mr Kumar a personal injury.[6] Mr Kumar has to prove causation on a balance of probabilities, and a Court may only draw a valid inference based on facts supported by the medical and other evidence and not on the basis of supposition or conjecture.[7] A temporal connection between Mr Kumar's hospital treatment and subsequent hepatitis C diagnosis, in itself, is insufficient to establish causation.[8]

[26] Mr Kumar submits there is a connection in time between his Wellington hospital treatment and subsequent hepatitis C diagnosis. He notes there is no evidence of any infection in his blood results from 13 January 2015, so his infection was more likely to have happened during his stay in hospital. He remembers receiving a blood transfusion in hospital, and his brother also witnessed this happening. Mr Kumar produced a photograph of himself receiving treatment (although it is not clear where and when the photograph taken and what treatment was being administered). Dr Lockwood, GP, said that it was "most likely" that Mr Kumar contracted hepatitis C as part of his emergency treatment in New Zealand.

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5 *Stewart v Accident Compensation Corporation* [2003] NZACC 109.
6 *Adlam*, above note 1, at [65].
7 *Ambros*, above note 2, at [65] and [67].

Mr Goswami's opinion is that a transfusion would have been required for Mr Kumar's brain haemorrhage treatment. Dr Flanagan's report confirms that Hepatitis C is a blood-borne infection. Mr Kumar does not have any other risk factors associated with hepatitis C.

[27] This Court acknowledges Mr Kumar's submissions. However, the Court refers to the following evidence.

[28] First, there is a gap of over a year between Mr Kumar's treatment at Wellington hospital (where he claimed he was infected with hepatitis C) and his diagnosis of having hepatitis C. There is therefore limited temporal connection between his hospital treatment and his later diagnosis. Further, as noted above, any temporal connection between Mr Kumar's hospital treatment and subsequent hepatitis C diagnosis, in itself, is insufficient to establish causation.

[29] Second, Dr Gibbons, the Corporation's clinical advisor and haematologist, noted that there was no evidence in the medical records that Mr Kumar underwent a blood transfusion. Dr Gibbons also noted that Mr Kumar did not undergo any blood tests for hepatitis C while he was in hospital, so it was impossible to know whether he had already contracted the condition by then. Dr Gibbons concluded that there was no evidence that Mr Kumar's hepatitis C was caused by his treatment.

[30] Third, the New Zealand Blood Service (NZBS) has confirmed that, while it performed a blood group test on Mr Kumar in its Wellington Blood Bank in 2015, it has never issued any blood to him for transfusion.

[31] Fourth, Dr Flanagan, Transfusion Medicine Specialist, reported that the absence of symptoms attributable to hepatitis C infection prior to Mr Kumar's admission to Wellington hospital did not exclude him already being infected with the virus. Dr Flanagan noted that there was no possibility of Mr Kumar contracting hepatitis C as a consequence of a blood group test, and his condition prior to surgery would not have warranted a blood transfusion. Dr Flanagan concluded that the absence of any record of transfusion during Mr Kumar's admission to hospital in

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[8] *Stewart*, above note 5, at [33].

2015, and the very low residual risk of hepatitis C associated with transfusion in New Zealand, indicated that he did not acquire the infection by this route.

Conclusion

[32] In light of the above four considerations, the Court finds that Mr Kumar has not established, on the balance of probabilities, that his hepatitis C was caused by hospital treatment he received for a brain haemorrhage. The decision of the Reviewer dated 7 June 2022 is therefore upheld. This appeal is dismissed.

[33] I make no order as to costs.

P R Spiller
District Court Judge

Solicitors for the Respondent: Meredith Connell